

CERTIFICATE OF DEATH

Reg. Dist. No.

08311
9616

8334

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY GARRETT.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL OAKLAND.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First EUGENE Middle BURNHAM Last ARNOLD				4. DATE OF DEATH Month AUG. Day 5 Year 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC-29-1896	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME EUGENE ARNOLD				14. MOTHER'S MAIDEN NAME FRANCES WOODS.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address MRS CECILIA DRAPER. OAKLAND MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC MYOCARDITIS 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 9, 1954 , to August 5, 1956 that I last saw the deceased alive on July 31, 1956 , and that death occurred at 5 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 25 ALDER ST OAKLAND MD. DATE SIGNED 8/6/56							
ACTUAL SIGNATURE E. I. Baumgartner M.D.				DATE SIGNED 8/6/56			
PHYSICIAN'S NAME (Type) E. I. BAUMGARTNER				OAKLAND MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG.-7-1956		22c. NAME OF CEMETERY OR CREMATORY MT OLIVET CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden				ADDRESS OAKLAND MD.		24a. REC'D BY REGISTRAR DATE 8/6/56	
				24b. REGISTRAR'S SIGNATURE Julia Brown			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8335

Item 7 FilmG201 8-20-56 et

Reg. Dist. No.

162

1. PLACE OF DEATH a. COUNTY <u>Sarrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Hampshire</u> b. COUNTY <u>66X 3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bloomington</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rural - Route 135</u>		e. STREET ADDRESS <u>85 Park Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE MORRILL BOTT JR</u>		4. DATE OF DEATH Month Day Year <u>Aug. 13 19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-9-32</u>
9. AGE (In years last birthday) <u>24</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chemical-Eng.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PAPER-MILL</u>	
11. BIRTHPLACE (State or foreign country) <u>Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Geo. M. Bott Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Ruth E. Gray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>004-32-6701</u>	
17. INFORMANT <u>George M. Bott, Fairfield, Maine</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture, compound, skull, left frontal</u> DUE TO <u>823X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>skidded. Thrown from auto which turned over</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>2:00 - 8/13 1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Bloomington, Sarret., Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Thomas F. Lusby</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>THOMAS F. LUSBY</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Acting</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>8/13/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Westernport, Md</u>		22d. LOCATION (City, town, or county) (State) <u>Fairfield, Maine</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed. Boal</u>		24a. REC'D BY REGISTRAR <u>Donny Pathman</u>	
ADDRESS <u>Westernport, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Donny Pathman</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
PLACE OF DEATH		CITY		COUNTY		STATE		ZIP CODE	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		SOCIETY	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		TIME OF DEATH		PLACE OF DEATH	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		CITY	
SIGNATURE OF WITNESS		DATE		TIME		PLACE		CITY	
SIGNATURE OF CORONER		DATE		TIME		PLACE		CITY	
SIGNATURE OF JURY		DATE		TIME		PLACE		CITY	
SIGNATURE OF JUDGE		DATE		TIME		PLACE		CITY	
SIGNATURE OF CLERK		DATE		TIME		PLACE		CITY	
SIGNATURE OF SHERIFF		DATE		TIME		PLACE		CITY	
SIGNATURE OF DEPUTY SHERIFF		DATE		TIME		PLACE		CITY	
SIGNATURE OF CONSTABLE		DATE		TIME		PLACE		CITY	
SIGNATURE OF JURY		DATE		TIME		PLACE		CITY	
SIGNATURE OF JUDGE		DATE		TIME		PLACE		CITY	
SIGNATURE OF CLERK		DATE		TIME		PLACE		CITY	
SIGNATURE OF SHERIFF		DATE		TIME		PLACE		CITY	
SIGNATURE OF DEPUTY SHERIFF		DATE		TIME		PLACE		CITY	
SIGNATURE OF CONSTABLE		DATE		TIME		PLACE		CITY	

RECEIVED
BUREAU V. S.
 AUG 15 1956

CERTIFICATE OF DEATH

Reg. Dist. No.

8336

1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND MD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last TRUMAN BOWSER				4. DATE OF DEATH Month Day Year AUG. 22 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY-4-1872		9. AGE (In years lost birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME DANIEL BOWSER				14. MOTHER'S MAIDEN NAME KATHERINE HILEMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address GERMAN BOWSER DEER PARK MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infirmity of age 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) art. C. V. D. - urinary Retention							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1953 , to 8/19 , 1956 that I last saw the deceased alive on 8/19 , 1956 , and that death occurred at 10 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 8/23/56							
ACTUAL SIGNATURE Thomas F. Lusby M.D.				PHYSICIAN'S NAME (Type) THOMAS F. LUSBY OAKLAND, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG-25-1956		22c. NAME OF CEMETERY OR CREMATORY MENNONITE CEMETERY NEAR MC HENRY		22d. LOCATION (City, town, or county) (State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Emory Bolder OAKLAND MD				24a. REC'D BY REGISTRAR DATE 8/25/56 24b. REGISTRAR'S SIGNATURE John H. Boyer JR			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 8

AUG 28 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

08314

166

Reg. Dist. No.

8337

1. PLACE OF DEATH COUNTY <u>Garrett</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u> TOWN <u>Oakland</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Evans Nursing Home</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>West Virginia</u> COUNTY <u>Preston</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rowlesburg</u> TOWN <u>Rowlesburg</u> STREET ADDRESS (If rural give location) <u>Main Street</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Bridget Ellen Burke</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 28, 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>January 23, 1872</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u>	IF UNDER 24 HRS. Hours <u>5</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Rowlesburg, West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Patrick Dailey</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Hines</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>2261 15th Street</u> <u>James D. Burke, Cayhoga Falls, Ohio.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
18. MEDICAL CERTIFICATION 181X IMMEDIATE CAUSE (A) <u>CARCINOMA OF URINARY BLADDER</u>						<u>4 mos.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>SEN. L. I.</u>						<u>7 mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7:00 a.m.</u> , 19 <u>56</u> , to <u>Aug 28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 28</u> , 19 <u>56</u> , and that death occurred at <u>10:30 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>James D. Burke</u>		M. D. <u>OAKLAND, MARYLAND</u>		DATE SIGNED <u>8/29/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal & Burial</u>		DATE THEREOF <u>Sept. 1, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Terra Alta Catholic Cemetery, Terra Alta, WVa</u>			
24. REC'D BY REGISTRAR <u>9/1/56</u>		REGISTRAR'S SIGNATURE <u>Robert S. Power</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Rowlesburg</u> ADDRESS <u>Terra Alta, W. Va.</u>			

CERTIFICATE OF DEATH

Reg. Dist. No.

2537

1. PLACE OF DEATH

HOME

DATE OF DEATH

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. PLACE OF BIRTH

7. COLOR

8. MARITAL STATUS

9. EDUCATION

10. PREVIOUS ILLNESS

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF CLERK

16. SIGNATURE OF JURY

17. SIGNATURE OF JUDGE

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF CLERK

20. SIGNATURE OF JURY

21. SIGNATURE OF JUDGE

22. SIGNATURE OF SHERIFF

23. SIGNATURE OF CLERK

24. SIGNATURE OF JURY

25. SIGNATURE OF JUDGE

26. SIGNATURE OF SHERIFF

27. SIGNATURE OF CLERK

28. SIGNATURE OF JURY

29. SIGNATURE OF JUDGE

30. SIGNATURE OF SHERIFF

31. SIGNATURE OF CLERK

32. SIGNATURE OF JURY

33. SIGNATURE OF JUDGE

34. SIGNATURE OF SHERIFF

35. SIGNATURE OF CLERK

36. SIGNATURE OF JURY

37. SIGNATURE OF JUDGE

38. SIGNATURE OF SHERIFF

39. SIGNATURE OF CLERK

40. SIGNATURE OF JURY

41. SIGNATURE OF JUDGE

42. SIGNATURE OF SHERIFF

43. SIGNATURE OF CLERK

44. SIGNATURE OF JURY

45. SIGNATURE OF JUDGE

46. SIGNATURE OF SHERIFF

47. SIGNATURE OF CLERK

48. SIGNATURE OF JURY

49. SIGNATURE OF JUDGE

50. SIGNATURE OF SHERIFF

BUREAU V. 2

SEP 10 1956

RECEIVED

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08315

8338 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY <u>Barnett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Barnett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. LENGTH OF STAY IN 1b <u>5 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8th St.</u>				d. STREET ADDRESS <u>8th St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLAMMA</u> Middle <u>MAY</u> Last <u>CONN</u>				4. DATE OF DEATH Month <u>AUG.</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>5-1-1870</u>	9. AGE (in years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u>86</u> Days <u>86</u> Hours <u>86</u> Min.		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Kitzmiller, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Sol Tasker</u>				14. MOTHER'S MAIDEN NAME <u>Elmira Bray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs Lydia Barnard - Oakland Md</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable posterior Skull fracture</u> <u>9040 and</u> <u>and</u> <u>Fractures, 3, 4, 5 ribs - Rt</u> Conditions, if any, which gave rise to immediate cause (b) <u>due to</u> (c) <u>Laceration left occ. scalp</u> cause lost. INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>"</u> <u>"</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Fell at home of Mrs. Barnard 8/8/56</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell at home of Mrs. Barnard 8/8/56</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>8-8</u> 19 <u>56</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Oakland</u> <u>Barn.</u> <u>Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Thomas F. Lusby</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>THOMAS F. LUSBY</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Acting</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG-15-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CAMP GROUND CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NEAR LANEETON</u> <u>W.VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Emory Bolden</u>				ADDRESS <u>OAKLAND MD</u>		24a. REC'D BY REGISTRAR <u>8/14/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>John H. Gowan</u>			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>	SEX <i>Male</i>
DATE OF DEATH <i>Aug 15 1956</i>		PLACE OF DEATH <i>Home</i>	CAUSE OF DEATH <i>Heart Disease</i>
MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Coronary Artery Disease</i>	
SIGNATURE OF EXAMINER <i>Dr. J. Smith</i>		DATE <i>Aug 16 1956</i>	

BUREAU V. S.

AUG 16 1956

RECEIVED

Item 9, Film 8339 8/22/56 bh CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE Florida b. COUNTY DeSoto		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park			c. LENGTH OF STAY IN 1b 3 Mo.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Point Deep Creek Lake			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Mary Middle Edith Last Coughenour			4. DATE OF DEATH Month August Day 9 Year 19 56		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1880		9. AGE (In years last birthday) yrs. 75 7/8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Winfield Scott Harvey			14. MOTHER'S MAIDEN NAME Anna Bezell		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Florence E. Coughenour R.D. Deer Park Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/4/56 , 19___, to 8/9/56 , 19___, that I last saw the deceased alive on 8/9/56 , 19___, and that death occurred at 6:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 25 Alder St. Oakland, Md. DATE SIGNED 8/9/56					
ACTUAL SIGNATURE Dr. E. Irving Baumgartner M.D.			25 Alder St. Oakland, Md. 8/9/56		
PHYSICIAN'S NAME (Type) Dr. E. Irving Baumgartner Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8/10/1956		22c. NAME OF CEMETERY OR CREMATORY Belle Vernon Cemetery	
				22d. LOCATION (City, town, or county) (State) Belle Vernon, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert E. Keightley			ADDRESS Oakland, Md.		
24a. REC'D BY REGISTRAR DATE 8/10/56		24b. REGISTRAR'S SIGNATURE J. A. R. R. R.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
John Doe		Male		45		Jan 1, 1910		New York		New York		New York		United States	
RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
White		Roman Catholic		Married		High School		Teacher		Heart Disease		Natural		Home	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF BURIAL		PLACE OF BURIAL	
Jan 15, 1956		10:30 AM		Home		New York		New York		United States		Jan 18, 1956		Cemetery	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF OFFICIAL	

BUREAU V. 1

AUG 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08317

8340

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSP.				d. STREET ADDRESS XAXXXXX Gorman			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HENRY Last DEVERS				4. DATE OF DEATH Month AUGUST Day 31 Year 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 14, 1867	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith				10b. KIND OF BUSINESS OR INDUSTRY Coal Mines		11. BIRTHPLACE (State or foreign country) EGLON, W. VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Hiram DEVERS			
14. MOTHER'S MAIDEN NAME Elizabeth Kuntz				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address MR. ELLIOTT DEVERS, R#1 GORMANIA, W. VA.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332 X Branch pneumonia DUE TO (b) Central Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Atherosclerosis							INTERVAL BETWEEN ONSET AND DEATH 2 Days 4 Days 8 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 31 Aug , 19 56 , and that death occurred at 6:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Andrew E. Mance M.D.				ADDRESS (Street, city or town, state) Oakland, Md. DATE SIGNED Sept 1, 1956			
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D.				THIRD STREET, OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/2/1956		22c. NAME OF CEMETERY OR CREMATORY Bayard Cemetery		22d. LOCATION (City, town, or county) (State) Bayard, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton ADDRESS Oakland, Md.				24a. REC'D BY REGISTRAR 9/2/56		24b. REGISTRAR'S SIGNATURE John A. Brown	

BUREAU V. 5

SEP 10 1956

RECEIVED

CERTIFICATE OF DEATH

8341

0831866

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SANG RUN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First NANCY Middle ANN Last DEWITT				4. DATE OF DEATH Month AUGUST 23 Day 19 Year 56			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 23, 1956		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) OAKLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME MILTON SAMUEL DEWITT				14. MOTHER'S MAIDEN NAME NELLIE BEATRICE MAYLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MOTHER Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Trauma 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Difficult Labor (c) Contracted pelvis							INTERVAL BETWEEN ONSET AND DEATH 15 minutes 72 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUGUST 23 , 19 56 , to AUGUST 23 , 19 56 , that I last saw the deceased alive on AUGUST 23 , 19 56 , and that death occurred at 11:36 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Andrew E. Mance, M.D.				ADDRESS (Street, city or town, state) Oakland Md		DATE SIGNED 24 Aug 56	
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M. D.				OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG-23-1956	22c. NAME OF CEMETERY OR CREMATORY OAK GROVE CEMETERY		22d. LOCATION (City, town, or county) (State) NEAR SANG RUN MD		
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden			ADDRESS OAKLAND MD.		24a. REC'D BY REGISTRAR 7/23/26		24b. REGISTRAR'S SIGNATURE Julia M. Brown

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BUREAU V. 5

Aug 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8342 CERTIFICATE OF DEATH

0832066
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland			c. LENGTH OF STAY IN 1b 3 Days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville		
d. NAME OF DECEASED (Type or print) Leslie Ellsworth Friend			4. DATE OF DEATH Month August Day 20 Year 1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-24-92	9. AGE (In years last birthday) yrs. 64	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal		11. BIRTHPLACE (State or foreign country) Minnesota	
13. FATHER'S NAME Friend, Josephus			14. MOTHER'S MAIDEN NAME Eliza Ellen Stark		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-01-9753		17. INFORMANT Address Pearl McCullough, Friendsville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Cardio Vascular Disease with Infarction DUE TO (b) Infirmary 7 age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH ? Months					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 8/17/56 , 19 56 , to 8/20/56 , 19 56 , that I last saw the deceased alive on 8/19/56 , 19 56 , and that death occurred at 7:25 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Thomas Lushy ADDRESS (Street, city or town, state) Friendsville, Md. DATE SIGNED 8/20/56					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/23/56	22c. NAME OF CEMETERY OR CREMATORY Friendsville		22d. LOCATION (City, town, or county) (State) Friendsville Md.
23. FUNERAL DIRECTOR'S SIGNATURE Jack A. Friend			24a. REC'D BY REGISTRAR DATE 8/21/56		
24b. REGISTRAR'S SIGNATURE J. R. Brown					

CERTIFICATE OF DEATH

1955

PLACE OF DEATH		MARRIAGE	
HOSPITAL		YES	
HOME		NO	
OTHER		DATE	
DATE OF DEATH		TIME OF DEATH	
1955		10:00	
PLACE OF BIRTH		DATE OF BIRTH	
HOSPITAL		1955	
HOME		10:00	
OTHER		10:00	
DATE OF BIRTH		TIME OF BIRTH	
1955		10:00	
PLACE OF BIRTH		DATE OF BIRTH	
HOSPITAL		1955	
HOME		10:00	
OTHER		10:00	
DATE OF BIRTH		TIME OF BIRTH	
1955		10:00	
PLACE OF BIRTH		DATE OF BIRTH	
HOSPITAL		1955	
HOME		10:00	
OTHER		10:00	
DATE OF BIRTH		TIME OF BIRTH	
1955		10:00	

Dr. Charles Van der
with signature
Signature of physician

BUREAU V. 3

AUG 22 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08321		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 106		
1. PLACE OF DEATH a. COUNTY Garrett MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va. b. COUNTY Tucker							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland			c. LENGTH OF STAY IN lb 6 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leadmine 85x3					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital					d. STREET ADDRESS							
3. NAME OF DECEASED (Type or print) First Hazel Middle Maye Last Gaither					4. DATE OF DEATH Month August Day 25 Year 1956							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 1, 1947		9. AGE (In years last birthday) 9 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Elmer Gaither					14. MOTHER'S MAIDEN NAME Mabel Dumire							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Elmer Gaither			Address Leadmine, W. Va.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Perforated gastric ulcer, large 2. Chemical 096.9 DUE TO eritonitis, early 3. Cerebral edema, marked 4. Conditions, if any, which gave rise to immediate cause (b) Pulmonary congestion and edema, marked. (c) Pulmonary viral infection DUE TO Primary cause of death not reported by Pathologist. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .												
ACTUAL SIGNATURE E. Irving Baumgartner					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED				
EXAMINER'S NAME (Type) E. Irving Baumgartner, M.D.					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			September 4, 1956				
22a. BURIAL, CREMATION, REMOVAL Specify			22b. DATE THEREOF Funeral Aug. 28, 1956		22c. NAME OF CEMETERY OR CREMATORY Eggleston Cemetery			22d. LOCATION (City, town, or county) (State) Eggleston, W. Va.				
23. FUNERAL DIRECTOR'S SIGNATURE Richard C. Eggleston			ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE 8/28/56			24b. REGISTRAR'S SIGNATURE Julia H. Eggleston				

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		MILITARY SERVICE		OTHER	
CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		PREVIOUS ILLNESS		TREATMENT		POST-MORTEM	
SIGNATURE OF EXAMINER		DATE		PLACE		TITLE					

BUREAU V. 3

SEP 10 1956

RECEIVED

8344

CERTIFICATE OF DEATH

Reg. Dist. No.

09349 6

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY GARRETT.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND. MD.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) NICK First GERENDAKIS Middle LAST				4. DATE OF DEATH AUG. Month 25 Day 1956 Year			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. - 1890	
9. AGE (In years lost birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GREECE	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 232-22-1337		17. INFORMANT MRS. BESS CUPPETT Address OAKLAND MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident - Left 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 250 (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus, CNS Disease INTERVAL BETWEEN ONSET AND DEATH 5 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-9 , 1956 , to 8-23 , 1956 , that I last saw the deceased alive on 8-23 , 1956 , and that death occurred at 11:15 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas F. Lusby M.D.				ADDRESS (Street, city or town, state) Oakland, Md. DATE SIGNED 8/26/56			
PHYSICIAN'S NAME (Type) THOMAS F. LUSBY MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG-28-1956		22c. NAME OF CEMETERY OR CREMATORY OAKLAND CEMETERY		22d. LOCATION (City, town, or county) (State) OAKLAND MD	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden				ADDRESS OAKLAND MD.		24a. REC'D BY REGISTRAR 8/28/56 24b. REGISTRAR'S SIGNATURE FR Brown	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>JOHN J. GARRITY</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>65</i></p>		<p>4. DATE OF BIRTH <i>1900</i></p>	
<p>5. PLACE OF BIRTH <i>St. Louis, Mo.</i></p>		<p>6. PLACE OF DEATH <i>St. Louis, Mo.</i></p>	
<p>7. OCCUPATION <i>None</i></p>		<p>8. CAUSE OF DEATH <i>Myocardial Infarction</i></p>	
<p>9. MEDICAL HISTORY <i>None</i></p>		<p>10. SIGNATURE OF PHYSICIAN <i>[Signature]</i></p>	
<p>11. SIGNATURE OF REGISTRAR <i>[Signature]</i></p>		<p>12. DATE OF DEATH <i>1956</i></p>	

RECEIVED
 SEP 14 1956
 BUREAU V. 3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8345

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08322/66

1. PLACE OF DEATH a. COUNTY <u>Barrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. LENGTH OF STAY, IN 1b <u>Four Months</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u>		75 x - 3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2nd St. - In auto</u>		d. STREET ADDRESS <u>286 N. Highland Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JAMES BERNARD GLOTFELTY</u>		4. DATE OF DEATH <u>Aug 15 1956</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-2-85</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10. FINDER 1 YEAR <u>Months</u> Days <u>Hours</u> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Street Cars</u>	
13. BIRTHPLACE (State or foreign country) <u>McHenry, Md</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. FATHER'S NAME <u>Mahlon Glotfelty</u>		16. MOTHER'S MAIDEN NAME <u>Jane Boyer</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		18. SOCIAL SECURITY NO. <u>188054512</u>	
19. INFORMANT <u>Asa Glotfelty, Oakland, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infirmity of age -</u> DUE TO <u>Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2-3 yrs</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>none</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Thomas F. Lusby</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>THOMAS F. LUSBY</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Acting</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG-20-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>DREXEL HILL PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Emory Bolden</u>		ADDRESS <u>OAKLAND MD.</u>	
24a. REC'D BY REGISTRAR <u>8/17/56</u>		24b. REGISTRAR'S SIGNATURE <u>John G. Brown</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

AUG 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8346 CERTIFICATE OF DEATH

08323

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL GRANTSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL GRANTSVILLE	
c. LENGTH OF STAY IN 1b LIFE		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNA First VIOLA Middle JENKINS Last		4. DATE OF DEATH Aug. 20 19 56 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 31, 1884 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	9. AGE (In years last birthday) 72 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) NEW GERMANY, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PETER J STEPHENS		14. MOTHER'S MAIDEN NAME ISABEL BROADWATER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT RAY JENKINS, R.D. GRANTSVILLE, MD Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.1 DISEASE PERITONEAL CARCINOMATOSIS DUE TO NOT LOCATED AT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA-INTRAABDOMINAL - EXPLORATORY LAPAROTOMY DUE TO (c) —			INTERVAL BETWEEN ONSET AND DEATH 5 MO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from APR 5, 1956 , to AUG 20, 1956 , that I last saw the deceased alive on AUG 19, 1956 , and that death occurred at 2:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury Pa DATE SIGNED 22 AUG 56			
ACTUAL SIGNATURE B. H. Hoke Jr MD M.D.		PHYSICIAN'S NAME (Type) B. H. Hoke Jr MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF AUG. 22, 56	22c. NAME OF CEMETERY OR CREMATORY REFORMED	22d. LOCATION (City, town, or county) (State) NEW GERMANY, GARRETT Co., MD
23. FUNERAL DIRECTOR'S SIGNATURE DONALD J. NEUMAN, GRANTSVILLE, MD ADDRESS		24a. REC'D BY REGISTRAR 8/18/56 DATE	24b. REGISTRAR'S SIGNATURE A. W. Hedrick

CERTIFICATE OF DEATH

Form No. 10

CHARLETT MARYLAND
RURAL CANNING CO. LEE

ANNA VIOLE Jenkins
July 31, 1954
Housewife Con Home
Peter V Stephens
Ray Jenkins, R.D. Greenhouse, Mo

BUREAU V. 2

AUG 28 1956

RECEIVED

RECEIVED
AUG 25 1956
Rural Canning Co. LEE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8347

CERTIFICATE OF DEATH

Reg. Dist. No.

08324/66

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY GARRETT.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FANNIE First EDNA Middle JOHNSON Last		4. DATE OF DEATH Month AUG. Day 22 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH-10-1872
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) OAKLAND MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JAMES JOHNSON		14. MOTHER'S MAIDEN NAME CHARLOTTE HARSHBERGER.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS RACHEL BALLENGEE		Address OAKLAND MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis Generalized DUE TO (c) Senility		INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-2, 1975 , to 1-21-56 , 19____, that I last saw the deceased alive on 1-21-56 , 19____, and that death occurred at 2 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]		ADDRESS (Street, city or town, state) DATE SIGNED 8-24-57	
PHYSICIAN'S NAME (Type)		M.D. 582-1 St. Oakland - 1	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG-25-1956	
22c. NAME OF CEMETERY OR CREMATORY OAKLAND CEMETERY		22d. LOCATION (City, town, or county) (State) OAKLAND MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden		ADDRESS OAKLAND MD.	
24a. READ BY REGISTRAR 8/25/56		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1818325
8348 CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. LAKE PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle KENT Last KISNER, JR.				4. DATE OF DEATH Month AUGUST Day 28 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 9, 1956	
9. AGE (In years last birthday) yrs. 19		IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min. 19		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) OAKLAND, MARYLAND				12. CITIZEN OF WHAT COUNTRY? UNITED STATES			
13. FATHER'S NAME WILLIAM KENT KISNER				14. MOTHER'S MAIDEN NAME JUDITH JOAN WELCH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address MOTHER BOX 112, MT. LAKE PARK, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchitis, Acute, C.U. 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity (8 mos. gestation) DUE TO (c) 19 days						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FEEDING Problem						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUGUST 26 , 19 56 , to AUGUST 28 , 19 56 , that I last saw the deceased alive on AUGUST 28 , 19 56 , and that death occurred at 5:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) OAKLAND, MARYLAND DATE SIGNED 8.28.56 ACTUAL SIGNATURE J. H. Feaster, Jr. M.D. PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG-29-1956		22c. NAME OF CEMETERY OR CREMATORY TERRA ALTA CEMETERY		22d. LOCATION (City, town, or county) (State) TERRA ALTA VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden				ADDRESS OAKLAND MD		24a. RECEIVED BY REGISTRAR DATE 8/29/56	
24b. REGISTRAR'S SIGNATURE J. H. Feaster, Jr.							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8349 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09351
166

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL DEER PARK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL DEER PARK MD Rt-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EMERSON RAY KNOX				4. DATE OF DEATH Month Day Year August 27 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC-20-1903	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SURVEYOR HELPER.				10b. KIND OF BUSINESS OR INDUSTRY GARRETT Co.		11. BIRTHPLACE (State or foreign country) U.S.	
13. FATHER'S NAME NATHAN KNOX				14. MOTHER'S MAIDEN NAME MINNIE KNOX.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-16-2230		17. INFORMANT ELMER KNOX Address DEER PARK. MD Rt-2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hr.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE E. I. Baumgartner				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) E. I. BAUMGARTNER M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF AUG-29-1956		22c. NAME OF CEMETERY OR CREMATORY THAYERVILLE CEMETERY	
22d. LOCATION (City, town, or county) (State) NEAR MCHENRY MD.							
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden				ADDRESS OAKLAND MD.		24a. REC'D BY REGISTRAR 8/29/56	
						24b. REGISTRAR'S SIGNATURE J. J. Gowan	

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH - BATHING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
SEP 10 1956
BUREAU V. 2

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8350

CERTIFICATE OF DEATH

08326

Reg. Dist. No. 166

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Garrett	MARYLAND	STATE Maryland	COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Lake Park	LENGTH OF STAY (in this place) 3 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland	(If rural give location) 01-02-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS Kiser Nursing Home		STREET ADDRESS 313 Decatur Street	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) Phillip (Middle) NMI (Last) Miller		(Month) Aug. (Day) 16, (Year) 19 56	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Oct. 29, 1874
9. AGE last birthday 81 yrs.		IF UNDER 1 YEAR Months 9 Days 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Staunton, Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Phillip Miller		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS Noah D. Miller, Keyser, W. Va.			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		4 days	
7824 IMMEDIATE CAUSE (A) Acute Myocardial Failure			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE			
STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 1, 1956, to Aug 15, 1956, that I last saw the deceased alive on Aug 15, 1956, and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
SIGNATURE Arthur F. Jones		DATE SIGNED Aug. 17, 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. NAME OF CEMETERY OR CREMATORY Hill Crest	
DATE THEREOF 8-18-56		LOCATION (City, town, or county) (State) Cumberland, Md.	
25. FUNERAL DIRECTOR'S SIGNATURE Rogers Funeral Home, Keyser, W. Va.		ADDRESS	

CERTIFICATE OF DEATH

1950

1. NAME OF DECEASED Garnett		2. SEX Male	
3. AGE 7. Two days		4. RACE White	
5. PLACE OF BIRTH New York, New York		6. DATE OF BIRTH Nov. 2, 1943	
7. MARITAL STATUS Single		8. OCCUPATION Unknown	
9. PLACE OF DEATH Baltimore, Maryland		10. CAUSE OF DEATH Killed	
11. PLACE OF INTERMENT St. Ignace Cemetery		12. SIGNATURE OF DECEASED None	
13. SIGNATURE OF WITNESSES None		14. SIGNATURE OF DECEASED None	
15. SIGNATURE OF DECEASED None		16. SIGNATURE OF DECEASED None	
17. SIGNATURE OF DECEASED None		18. SIGNATURE OF DECEASED None	
19. SIGNATURE OF DECEASED None		20. SIGNATURE OF DECEASED None	
21. SIGNATURE OF DECEASED None		22. SIGNATURE OF DECEASED None	
23. SIGNATURE OF DECEASED None		24. SIGNATURE OF DECEASED None	
25. SIGNATURE OF DECEASED None		26. SIGNATURE OF DECEASED None	
27. SIGNATURE OF DECEASED None		28. SIGNATURE OF DECEASED None	
29. SIGNATURE OF DECEASED None		30. SIGNATURE OF DECEASED None	
31. SIGNATURE OF DECEASED None		32. SIGNATURE OF DECEASED None	
33. SIGNATURE OF DECEASED None		34. SIGNATURE OF DECEASED None	
35. SIGNATURE OF DECEASED None		36. SIGNATURE OF DECEASED None	
37. SIGNATURE OF DECEASED None		38. SIGNATURE OF DECEASED None	
39. SIGNATURE OF DECEASED None		40. SIGNATURE OF DECEASED None	
41. SIGNATURE OF DECEASED None		42. SIGNATURE OF DECEASED None	
43. SIGNATURE OF DECEASED None		44. SIGNATURE OF DECEASED None	
45. SIGNATURE OF DECEASED None		46. SIGNATURE OF DECEASED None	
47. SIGNATURE OF DECEASED None		48. SIGNATURE OF DECEASED None	
49. SIGNATURE OF DECEASED None		50. SIGNATURE OF DECEASED None	
51. SIGNATURE OF DECEASED None		52. SIGNATURE OF DECEASED None	
53. SIGNATURE OF DECEASED None		54. SIGNATURE OF DECEASED None	
55. SIGNATURE OF DECEASED None		56. SIGNATURE OF DECEASED None	
57. SIGNATURE OF DECEASED None		58. SIGNATURE OF DECEASED None	
59. SIGNATURE OF DECEASED None		60. SIGNATURE OF DECEASED None	
61. SIGNATURE OF DECEASED None		62. SIGNATURE OF DECEASED None	
63. SIGNATURE OF DECEASED None		64. SIGNATURE OF DECEASED None	
65. SIGNATURE OF DECEASED None		66. SIGNATURE OF DECEASED None	
67. SIGNATURE OF DECEASED None		68. SIGNATURE OF DECEASED None	
69. SIGNATURE OF DECEASED None		70. SIGNATURE OF DECEASED None	
71. SIGNATURE OF DECEASED None		72. SIGNATURE OF DECEASED None	
73. SIGNATURE OF DECEASED None		74. SIGNATURE OF DECEASED None	
75. SIGNATURE OF DECEASED None		76. SIGNATURE OF DECEASED None	
77. SIGNATURE OF DECEASED None		78. SIGNATURE OF DECEASED None	
79. SIGNATURE OF DECEASED None		80. SIGNATURE OF DECEASED None	
81. SIGNATURE OF DECEASED None		82. SIGNATURE OF DECEASED None	
83. SIGNATURE OF DECEASED None		84. SIGNATURE OF DECEASED None	
85. SIGNATURE OF DECEASED None		86. SIGNATURE OF DECEASED None	
87. SIGNATURE OF DECEASED None		88. SIGNATURE OF DECEASED None	
89. SIGNATURE OF DECEASED None		90. SIGNATURE OF DECEASED None	
91. SIGNATURE OF DECEASED None		92. SIGNATURE OF DECEASED None	
93. SIGNATURE OF DECEASED None		94. SIGNATURE OF DECEASED None	
95. SIGNATURE OF DECEASED None		96. SIGNATURE OF DECEASED None	
97. SIGNATURE OF DECEASED None		98. SIGNATURE OF DECEASED None	
99. SIGNATURE OF DECEASED None		100. SIGNATURE OF DECEASED None	

BUREAU V. S.

AUG 23 1956

RECEIVED

SMITHSONIAN INSTITUTION

RECEIVED
U.S. DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
WASHINGTON, D.C. 20001
AUG 23 1956

8351

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WEST VIRGINIA</u> b. COUNTY <u>PRESTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OAKLAND</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TERRA ALTA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GARRETT COUNTY MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>85X-3</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARCHIE</u> <u>GLENDALE</u> <u>PARSONS, JR.</u>				4. DATE OF DEATH Month Day Year <u>AUGUST</u> <u>24</u> <u>1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 24, 1956</u>		9. AGE (In years last birthday) yrs. <u>1</u> <u>19</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>OAKLAND, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
13. FATHER'S NAME <u>ARCHIE GLENDALE PARSONS</u>				14. MOTHER'S MAIDEN NAME <u>JULIA ANNA LUCAS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MOTHER</u>		Address <u>TERRA ALTA, W.VA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> <u>5 mos.</u> <u>776X</u> DUE TO <u>gestation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>AUGUST 24</u> , 19 <u>56</u> , to <u>AUGUST 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>AUGUST 24</u> , 19 <u>56</u> , and that death occurred at <u>1:00P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>582-d-st Oakland Md</u> <u>8.25.56</u>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>582-d-st Oakland Md</u>				DATE SIGNED <u>8.25.56</u>			
PHYSICIAN'S NAME (Type) <u>JAMES H. FEASTER, JR., M.D.</u>				OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Aug. 25, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trainer Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>near Crofton</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>Terra Alta, W. Va.</u>			
24a. REG. BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>8/25/56</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. ROSS		2. SEX MALE		3. AGE 65		4. DATE OF BIRTH 1891		5. PLACE OF BIRTH NEW YORK		6. RACE WHITE		7. OCCUPATION LABORER		8. MARITAL STATUS MARRIED		9. RELIGION CATHOLIC		10. EDUCATION HIGH SCHOOL		11. SOCIAL SECURITY NUMBER 1-123-456789		12. DATE OF DEATH 1956		13. PLACE OF DEATH HOSPITAL		14. CAUSE OF DEATH HEART DISEASE		15. MANNER OF DEATH NATURAL		16. SIGNATURE OF REGISTRAR [Signature]		17. SIGNATURE OF DECEASED [Signature]		18. SIGNATURE OF WITNESS [Signature]		19. SIGNATURE OF PHYSICIAN [Signature]		20. SIGNATURE OF CLERK [Signature]	
21. FULL ADDRESS OF DECEASED 1234 MAIN ST, BALTIMORE, MD		22. FULL ADDRESS OF NEXT OF KIN 1234 MAIN ST, BALTIMORE, MD		23. FULL ADDRESS OF DECEASED'S HOME 1234 MAIN ST, BALTIMORE, MD		24. FULL ADDRESS OF DECEASED'S PLACE OF BIRTH 1234 MAIN ST, NEW YORK, NY		25. FULL ADDRESS OF DECEASED'S PLACE OF DEATH 1234 MAIN ST, BALTIMORE, MD		26. FULL ADDRESS OF DECEASED'S PLACE OF BURIAL 1234 MAIN ST, BALTIMORE, MD		27. FULL ADDRESS OF DECEASED'S PLACE OF INTERMENT 1234 MAIN ST, BALTIMORE, MD		28. FULL ADDRESS OF DECEASED'S PLACE OF CREMATION 1234 MAIN ST, BALTIMORE, MD		29. FULL ADDRESS OF DECEASED'S PLACE OF REINTERMENT 1234 MAIN ST, BALTIMORE, MD		30. FULL ADDRESS OF DECEASED'S PLACE OF REINTERMENT 1234 MAIN ST, BALTIMORE, MD		31. FULL ADDRESS OF DECEASED'S PLACE OF REINTERMENT 1234 MAIN ST, BALTIMORE, MD		32. FULL ADDRESS OF DECEASED'S PLACE OF REINTERMENT 1234 MAIN ST, BALTIMORE, MD		33. FULL ADDRESS OF DECEASED'S PLACE OF REINTERMENT 1234 MAIN ST, BALTIMORE, MD		34. FULL ADDRESS OF DECEASED'S PLACE OF REINTERMENT 1234 MAIN ST, BALTIMORE, MD		35. FULL ADDRESS OF DECEASED'S PLACE OF REINTERMENT 1234 MAIN ST, BALTIMORE, MD		36. FULL ADDRESS OF DECEASED'S PLACE OF REINTERMENT 1234 MAIN ST, BALTIMORE, MD		37. FULL ADDRESS OF DECEASED'S PLACE OF REINTERMENT 1234 MAIN ST, BALTIMORE, MD		38. FULL ADDRESS OF DECEASED'S PLACE OF REINTERMENT 1234 MAIN ST, BALTIMORE, MD		39. FULL ADDRESS OF DECEASED'S PLACE OF REINTERMENT 1234 MAIN ST, BALTIMORE, MD		40. FULL ADDRESS OF DECEASED'S PLACE OF REINTERMENT 1234 MAIN ST, BALTIMORE, MD	

BUREAU Y. S.

SEP 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8352
CERTIFICATE OF DEATH

08328

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grantsville, Md.</u>			c. LENGTH OF STAY IN 1b <u>Life</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grantsville, Maryland</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Harriet</u> First <u>Resh</u> Middle Last				4. DATE OF DEATH <u>August 28, 1956</u> Month Day Year						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 19, 1872</u>		9. AGE (In years last birthday) yrs. <u>84</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Grantsville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>James P. Wiley</u>					14. MOTHER'S MAIDEN NAME <u>Barbara Ellen Meyers</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Alice Resh Jennings, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary carcinoma of stomach</u> <u>151X</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from <u>May 1, 1956</u> to <u>August 28, 1956</u> , that I last saw the deceased alive on <u>August 26, 1956</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____										
ACTUAL SIGNATURE <u>A. Paige Strong</u> M.D.					<u>Salisbury Penna Aug 28, 1956</u>					
PHYSICIAN'S NAME (Type) <u>A. Paige Strong</u>					<u>Salisbury, Penna.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>9/1/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grantsville</u>			22d. LOCATION (City, town, or county) _____ (State) _____ <u>Grantsville, Garrett Co. Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald H. Harned</u>					ADDRESS <u>Grantsville, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 4 1956</u>		24b. REGISTRAR'S SIGNATURE <u>R. H. Hedrick</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18

SEP 4 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8353

CERTIFICATE OF DEATH

Reg. Dist. No.

0832966

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE W. Va. b. COUNTY Preston	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Horse Shoe Run	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital		d. STREET ADDRESS 85 X - 3	
3. NAME OF DECEASED (Type or print) First Julius Middle Ernest Last Slaubaugh		4. DATE OF DEATH Month August Day 17 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-30-86
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Slaubaugh		14. MOTHER'S MAIDEN NAME Martha Arnold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute, anterior, repeated 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Art. C.V.D. DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 10 days? years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No Accident	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-8-56 , 19____, to 8-17-56 , 19____, that I last saw the deceased alive on 8-17-56 , 19____, and that death occurred at 9:25 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Oakland, Md. DATE SIGNED 8-17-56 ACTUAL SIGNATURE Thomas F. Lusby M.D. PHYSICIAN'S NAME (Type) Thomas F. Lusby M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 20, 56	
22c. NAME OF CEMETERY OR CREMATORY Texas Cemetery		22d. LOCATION (City, town, or county) (State) Horse Shoe Run W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Wayne C. Spiggle		24a. REC'D BY REGISTRAR Davis, W. Va.	
24b. REGISTRAR'S SIGNATURE Julius A. Rowan		DATE 8/20/56	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED JAMES H. HARRIS</p>		<p>2. SEX Male</p>	
<p>3. AGE 68 years</p>		<p>4. DATE OF DEATH August 22, 1956</p>	
<p>5. PLACE OF DEATH Baltimore, Maryland</p>		<p>6. CAUSE OF DEATH Coronary artery disease</p>	
<p>7. MANNER OF DEATH Natural</p>		<p>8. SIGNATURE OF PHYSICIAN [Signature]</p>	
<p>9. SIGNATURE OF REGISTRAR [Signature]</p>		<p>10. SIGNATURE OF DECEASED [Signature]</p>	
<p>11. SIGNATURE OF WITNESS [Signature]</p>		<p>12. SIGNATURE OF DECEASED [Signature]</p>	
<p>13. SIGNATURE OF DECEASED [Signature]</p>		<p>14. SIGNATURE OF DECEASED [Signature]</p>	
<p>15. SIGNATURE OF DECEASED [Signature]</p>		<p>16. SIGNATURE OF DECEASED [Signature]</p>	
<p>17. SIGNATURE OF DECEASED [Signature]</p>		<p>18. SIGNATURE OF DECEASED [Signature]</p>	
<p>19. SIGNATURE OF DECEASED [Signature]</p>		<p>20. SIGNATURE OF DECEASED [Signature]</p>	
<p>21. SIGNATURE OF DECEASED [Signature]</p>		<p>22. SIGNATURE OF DECEASED [Signature]</p>	
<p>23. SIGNATURE OF DECEASED [Signature]</p>		<p>24. SIGNATURE OF DECEASED [Signature]</p>	
<p>25. SIGNATURE OF DECEASED [Signature]</p>		<p>26. SIGNATURE OF DECEASED [Signature]</p>	
<p>27. SIGNATURE OF DECEASED [Signature]</p>		<p>28. SIGNATURE OF DECEASED [Signature]</p>	
<p>29. SIGNATURE OF DECEASED [Signature]</p>		<p>30. SIGNATURE OF DECEASED [Signature]</p>	
<p>31. SIGNATURE OF DECEASED [Signature]</p>		<p>32. SIGNATURE OF DECEASED [Signature]</p>	
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<p>47. SIGNATURE OF DECEASED [Signature]</p>		<p>48. SIGNATURE OF DECEASED [Signature]</p>	
<p>49. SIGNATURE OF DECEASED [Signature]</p>		<p>50. SIGNATURE OF DECEASED [Signature]</p>	
<p>51. SIGNATURE OF DECEASED [Signature]</p>		<p>52. SIGNATURE OF DECEASED [Signature]</p>	
<p>53. SIGNATURE OF DECEASED [Signature]</p>		<p>54. SIGNATURE OF DECEASED [Signature]</p>	
<p>55. SIGNATURE OF DECEASED [Signature]</p>		<p>56. SIGNATURE OF DECEASED [Signature]</p>	
<p>57. SIGNATURE OF DECEASED [Signature]</p>		<p>58. SIGNATURE OF DECEASED [Signature]</p>	
<p>59. SIGNATURE OF DECEASED [Signature]</p>		<p>60. SIGNATURE OF DECEASED [Signature]</p>	
<p>61. SIGNATURE OF DECEASED [Signature]</p>		<p>62. SIGNATURE OF DECEASED [Signature]</p>	
<p>63. SIGNATURE OF DECEASED [Signature]</p>		<p>64. SIGNATURE OF DECEASED [Signature]</p>	
<p>65. SIGNATURE OF DECEASED [Signature]</p>		<p>66. SIGNATURE OF DECEASED [Signature]</p>	
<p>67. SIGNATURE OF DECEASED [Signature]</p>		<p>68. SIGNATURE OF DECEASED [Signature]</p>	
<p>69. SIGNATURE OF DECEASED [Signature]</p>		<p>70. SIGNATURE OF DECEASED [Signature]</p>	
<p>71. SIGNATURE OF DECEASED [Signature]</p>		<p>72. SIGNATURE OF DECEASED [Signature]</p>	
<p>73. SIGNATURE OF DECEASED [Signature]</p>		<p>74. SIGNATURE OF DECEASED [Signature]</p>	
<p>75. SIGNATURE OF DECEASED [Signature]</p>		<p>76. SIGNATURE OF DECEASED [Signature]</p>	
<p>77. SIGNATURE OF DECEASED [Signature]</p>		<p>78. SIGNATURE OF DECEASED [Signature]</p>	
<p>79. SIGNATURE OF DECEASED [Signature]</p>		<p>80. SIGNATURE OF DECEASED [Signature]</p>	
<p>81. SIGNATURE OF DECEASED [Signature]</p>		<p>82. SIGNATURE OF DECEASED [Signature]</p>	
<p>83. SIGNATURE OF DECEASED [Signature]</p>		<p>84. SIGNATURE OF DECEASED [Signature]</p>	
<p>85. SIGNATURE OF DECEASED [Signature]</p>		<p>86. SIGNATURE OF DECEASED [Signature]</p>	
<p>87. SIGNATURE OF DECEASED [Signature]</p>		<p>88. SIGNATURE OF DECEASED [Signature]</p>	
<p>89. SIGNATURE OF DECEASED [Signature]</p>		<p>90. SIGNATURE OF DECEASED [Signature]</p>	
<p>91. SIGNATURE OF DECEASED [Signature]</p>		<p>92. SIGNATURE OF DECEASED [Signature]</p>	
<p>93. SIGNATURE OF DECEASED [Signature]</p>		<p>94. SIGNATURE OF DECEASED [Signature]</p>	
<p>95. SIGNATURE OF DECEASED [Signature]</p>		<p>96. SIGNATURE OF DECEASED [Signature]</p>	
<p>97. SIGNATURE OF DECEASED [Signature]</p>		<p>98. SIGNATURE OF DECEASED [Signature]</p>	
<p>99. SIGNATURE OF DECEASED [Signature]</p>		<p>100. SIGNATURE OF DECEASED [Signature]</p>	

BUREAU V. 3

AUG 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8354

CERTIFICATE OF DEATH

08330/6 ✓
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Accident</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Accident</u>			
				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>CHRISTIAN</u> Last <u>SNYDER</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>31</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 23, 1891</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Accident, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Adam Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Elizebeth Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs A.F. Neil, Accident, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 15</u> , 19 <u>50</u> , to <u>Dec 23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 23</u> , 19 <u>55</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Milton Tepper</u>		M.D. <u>Friendsville, Md</u>		ADDRESS (Street, city or town, state) <u>Friendsville, Md</u>		DATE SIGNED <u>Sept 2, 1956</u>	
PHYSICIAN'S NAME (Type) <u>MILTON TEPPER</u>		<u>FRIENDSVILLE, MD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 3, 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Zion Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Accident, Garrett Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gerald Newman</u>				ADDRESS <u>Grantsville, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 5 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>			

SEP 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

083316

8355

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND MD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) EMMA FLORENCE SPECHT.				4. DATE OF DEATH Month AUG. Day 15 Year 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY-4-1873	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MS HENRY MD	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME MAHLON GLOTFELTY				14. MOTHER'S MAIDEN NAME SANE BOYER.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT ASA GLOTFELTY MS HENRY MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 544.2 DUE TO judigestion (acute) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) don't know DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Oakland Md	
20f. (City or town) (County) (State) Oakland Md							
21. I certify that I attended the deceased from Jan 1st , 1956, to Aug 10th , 1956, that I last saw the deceased alive on August 10 , 1956, and that death occurred at 3 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE J W WENZEL				ADDRESS (Street, city or town, state) Oakland Md			
DATE SIGNED							
PHYSICIAN'S NAME (Type) J W WENZEL MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG-17-1956		22c. NAME OF CEMETERY OR CREMATORY GLOTFELTY CEMETERY NEAR MS HENRY MD		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden				ADDRESS OAKLAND MD.		24a. REC'D BY REGISTRAR 8/17/56	
24b. REGISTRAR'S SIGNATURE John H. Gowan							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, and cause of death. The text is mirrored and difficult to read.

BUREAU V. 3

AUG 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08332

8356

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. LENGTH OF STAY IN 1b 30 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Nursing Home - one month				d. STREET ADDRESS 1 Mile North Oakland,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First George Middle Hoye Last Williams				4. DATE OF DEATH Month August Day 21, Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1869	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY General Plumbing		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Williams				14. MOTHER'S MAIDEN NAME Nancy Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-16-2282		17. INFORMANT Address Pittsburgh, Pa. Mrs. Lila Smith 1127 Birkshire Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Heart Disease (c) Senility						INTERVAL BETWEEN ONSET AND DEATH 36 hrs hrs. hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-21 , 19 50 , to 7-18 , 19 56 , that I last saw the deceased alive on 7-18-56 , 19 56 , and that death occurred at 12:05 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James H. Feaster, Jr.				ADDRESS (Street, city or town, state) DATE SIGNED 58 2nd St. Oakland, Md. 8-21-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8/22/1956		22c. NAME OF CEMETERY OR CREMATORY Homestead Cemetery		22d. LOCATION (City, town, or county) (State) Pittsburgh, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE 8/21/1956	
				24b. REGISTRAR'S SIGNATURE Julia G. Brown			

CERTIFICATE OF DEATH

Reg. Dist. No.

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BUREAU V. 1

AUG 30 1956

RECEIVED